SEATTLE PSYCHOANALYTIC SOCIETY AND INSTITUTE

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SPSI Psychoanalytic Referral Service Information Form

☐ **I would like to be included in SPSI's Psychoanalytic Referral Service.**
If so, please send proof of your malpractice insurance coverage and complete the form below.

Name and Degree(s): _____

Work Address: _____

Work Phone: _____ Work Email: _____

☐ I have completed one year of SPSI's Psychoanalytic Psychotherapy Program.

☐ I am an 4-year Program / APPP / CPP / CAPP / PPP graduate.

☐ I am a Candidate. ☐ I am a graduate analyst.

☐ I am available for **psychotherapy** referrals. My fee range is _____ to _____

☐ I am available for **psychoanalytic** referrals. My fee range is _____ to _____

☐ I offer sliding scale rates.

I accept the following insurance plans:

My particular field(s) of interest are: (optional)

These are certain referrals I would not accept: (optional)

☐ I am willing to see patients requiring medication management.